

2020 and 11/01/2021 and included questions relating to pre-COVID ECT (June 2019 to February 2020) and during-COVID ECT (March 2020 to November 2020). Questions were around travel of staff/patients for ECT, whether they had a preference for a model and their reasons around it. Data were summarised in MS Excel and free text comments analysed to gain an understanding of staff's preferences and reasoning behind their choices. **Result.** Although some boroughs had patients attending from other boroughs in pre-COVID times, considerably more staff (53.85%) and patients (61.54%) had to travel for ECT during COVID times. Around 50% staff expressed a clear view for decentralised services; the common reasons being safer for patients, better continuity of care, less travelling issues, patients more likely to consent, easier to manage correct paperwork, easier to send staff who knows patients well, less driving for staff and likely less cancellations. Around 40% staff expressed a clear view for centralised services; the common reasons being less staff needed, better infection control, easier to maintain staff skills, efficiency, developing clinical expertise with larger number of cases, education opportunities, better set-up of clinics, transportation and accessibility. Some concerns raised for the centralised model were managing patients with complex anaesthesia, travelling for unwell/ disturbed patients, too high patient numbers, poor communication and impact on training.

Conclusion. In summary, there was a mixed view of which services are preferable. Further discussion in trust wide ECT forum will be helpful to move things forward. Although it is likely that services may shift from a decentralised to a centralised system, we need to ensure this is done safely and in particular, address the main concerns around centralisation.

Preliminary investigation into the identification and management of catatonia in patients admitted to adult inpatient units

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Aims. The prevalence of catatonia is considered to be approximately 10% in psychiatric inpatients. Clinical experience suggests a lower documented prevalence. This could cause longer admissions and complications, such as Neuroleptic Malignant Syndrome (NMS). We carried out a service evaluation to investigate the recognition and management of catatonia on inpatient units in Southern Health Foundation Trust (SHFT). We reviewed the local documented prevalence of catatonia, treatment offered and prevalence of complications.

Method. We retrospectively reviewed the electronic records of 95 consecutive admissions to four adult inpatient units in SHFT, starting on 1st August 2020. We reviewed notes for the admission to establish whether catatonia was suspected and identified. We applied the screening questions from the Bush-Francis Catatonia Rating Scale (BFCRS) to the documented mental state examinations (MSE) prior to, and shortly after, admission. We also recorded the prescriptions issued during the first 72 hours of admission, and whether patients developed neuroleptic malignant syndrome (NMS), serotonin syndrome or required admission to a general hospital during admission.

Result. Catatonia was documented as a possibility for 2 patients (2.1%). One showed possible posturing and stupor, while there

were no documented symptoms for the other. In both cases the possibility was discounted by the clinical team. Twelve patients (12.6%) showed one or more possible or confirmed signs of catatonia. Eleven of these were prescribed regular antipsychotic medication on admission, but only 3 were prescribed regular benzodiazepines. NMS was more likely to be suspected in patients with a BFCRS of 1 or more compared with those with a score of 0, with an odds ratio of 8.1 (95% CI [1.03-64.0], Fisher's exact test = 7.79, $p = .076$).

Conclusion. Catatonia is likely under-recognised and under-treated locally among psychiatric inpatients. Although only approaching statistical significance, the higher rate of suspected NMS in patients showing possible catatonia is noteworthy and needs further investigation. Regular benzodiazepines were not frequently prescribed in this group, while antipsychotics, prescribed in all of these patients, can precipitate NMS. Alternatively, this finding could reflect the overlap in clinical presentation between NMS and catatonia. Data collection was limited by the frequent use of "remote clerking", in the context of the COVID-19 pandemic. Additionally, the quality of mental state examinations was often not sufficient to draw any conclusions on the possible presence or absence of catatonic symptoms. This project has highlighted practice in need of improvement, which will be further prospectively investigated and improved via a Quality Improvement Project.

Physical health monitoring of patients prescribed depot antipsychotic medication in north west Edinburgh community mental health team

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Aims. To monitor the quality of physical health monitoring of patients prescribed depot antipsychotic medication in the North West Edinburgh Community Mental Health Team (CMHT). We also evaluated the completeness of prescriptions and Mental Health Act (Scotland) (Act) 2003 paperwork where relevant.

Background. Antipsychotic medications are medicines for treating conditions such as Schizophrenia, but some may be associated with an increased risk of Metabolic Syndrome. Moreover, evidence indicates that patients with major mental disorder have a reduced life expectancy in comparison to those without such diagnoses. These two factors illustrate the importance of the physical health of this patient cohort being monitored on a regular basis. This project will evaluate how a local CMHT is performing, with the possibility of enacting service improvements if required.

Method. The records of the 60 patients prescribed depot antipsychotic medication administered by this CMHT were reviewed. A check-list was created consisting of 14 categories analysing the quality of physical health monitoring, as well as compliance with prescription standards and, where relevant, Mental Health Act (Scotland) (Act) 2003 paperwork. We compared patient records against our checklist for the calendar year of 2019. The Scottish Intercollegiate Guidelines Network (SIGN) 131 (Management of Schizophrenia) section 5.2 was used as the gold standard for physical health monitoring against which the data we collected was compared.